Bringing Pae Ora to life: He aha tāku mahi āpōpō?

Dr Dougal Thorburn; Waikato-Tainui; Specialist General Practitioner (Ora Toa Health services); Public Health Medicine Specialist (National Screening Unit)

Collaborative Aotearoa Symposium

Wharewaka, Whanganui-a-Tara

1 September 2022

Photo: Southernnatives.co.nz

"E kore au e ngaro, he kākano i ruia mai i Rangiātea.“

'I shall never be lost, I am a seed sown from Rangiātea.'

Kaupapa

Mihi

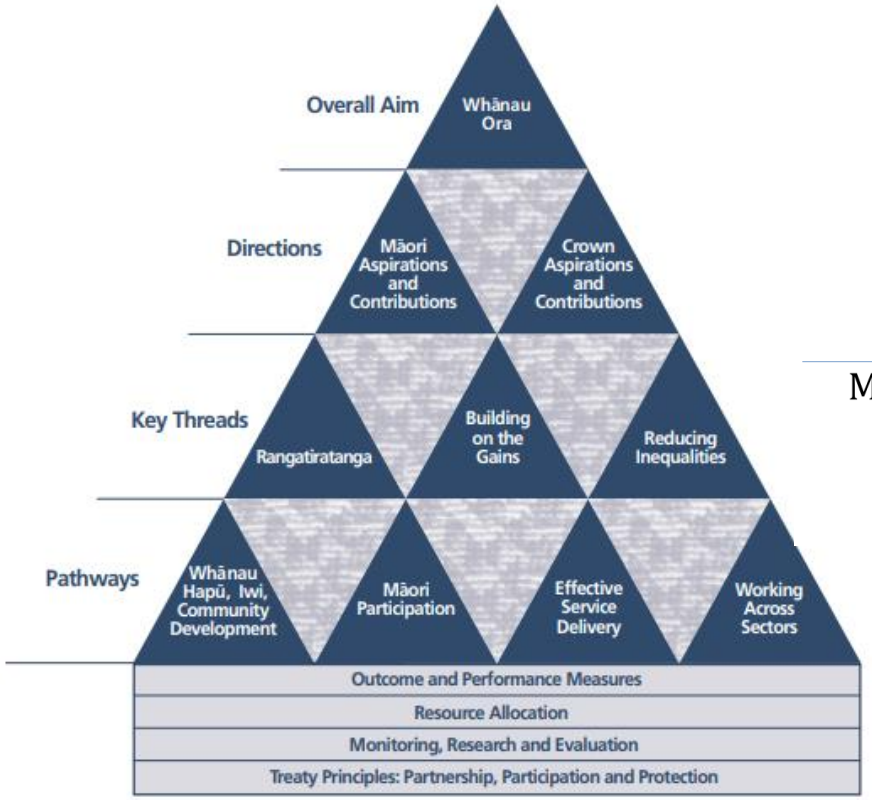
What do I need to do tomorrow to:

- Achieve Pae Ora?
- Enable high quality primary and community health care in my locality?

Poroporoaki

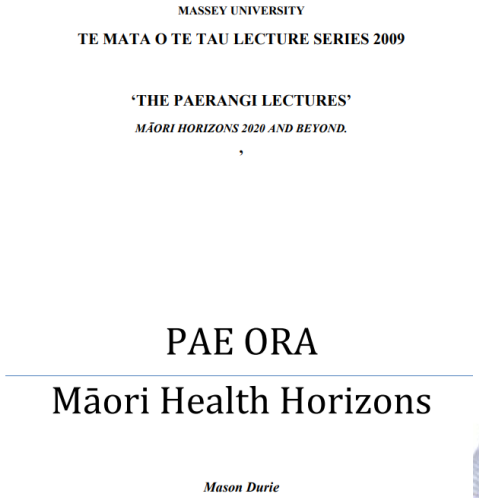
Pae Ora

2002



Ministry of Health. 2002. He Korowai Oranga: Māori Health Strategy 2014. Wellington: Ministry of Health.

2009


MASSEY UNIVERSITY

TE MATA O TE TAU LECTURE SERIES 2009

'THE PAERANGI LECTURES'

MĀORI HORIZONS 2020 AND BEYOND.

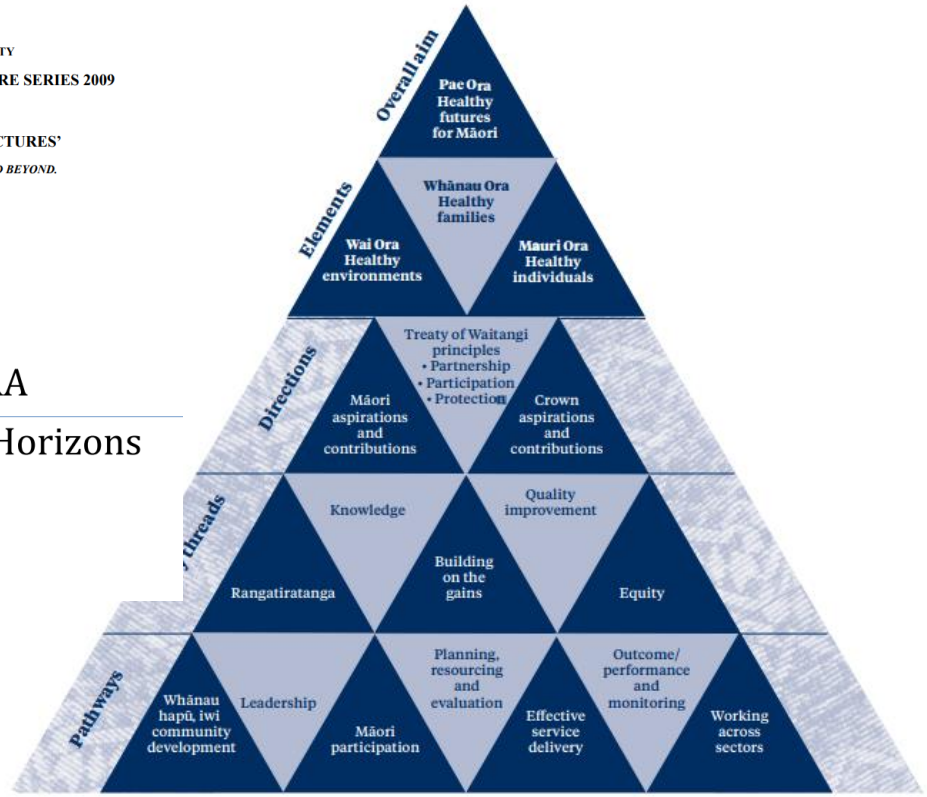
,

PAE ORA

Māori Health Horizons

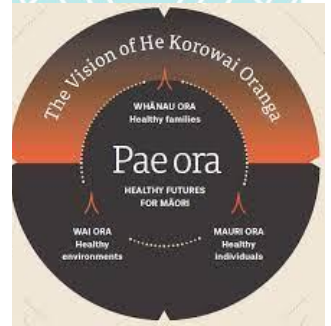
Mason Durie

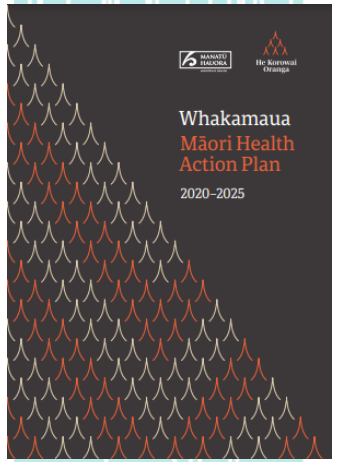
2014



Ministry of Health. 2014. The Guide to He Korowai Oranga: Māori Health Strategy 2014. Wellington: Ministry of Health.

2020





The principles of Te Tiriti o Waitangi

- **Partnership**
  requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services.
- **Options**
  requires the Crown to provide for and properly resource kaupapa Māori health and disability services.
- **Tino-Rangatiratanga**
  provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- **Active Protection**
  which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori
- **Equity**
  requires the Crown to commit to achieving equitable health outcomes for Māori.

We have a duty under the Pae Ora Act to align our activities with the Principles of Te Tiriti o Waitangi

7 Health sector principles

(1) For the purpose of this Act, the health sector principles are as follows:

(a) the health sector should be equitable, which includes ensuring Māori and other population groups—

(i) have access to services in proportion to their health needs; and

(ii) receive equitable levels of service; and

(iii) achieve equitable health outcomes:

(b) the health sector should engage with Māori, other population groups, and other people to develop and deliver services and programmes that reflect their needs and aspirations, for example, by engaging with Māori to develop, deliver, and monitor services and programmes designed to improve hauora Māori outcomes:

(c) the health sector should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori and for that purpose, have regard to both—

(i) the strength or nature of Māori interests in a matter; and

(ii) the interests of other health consumers and the Crown in the matter:

(d) the health sector should provide choice of quality services to Māori and other population groups, including by—

(i) resourcing services to meet the needs and aspirations of iwi, hapū, and whānau, and Māori (for example, kaupapa Māori and whānau-centred services); and

(ii) providing services that are culturally safe and culturally responsive to people's needs; and

(iia) developing and maintaining a health workforce that is representative of the community it serves; and

(iii) harnessing clinical leadership, innovation, technology, and lived experience to continuously improve services, access to services, and health outcomes; and

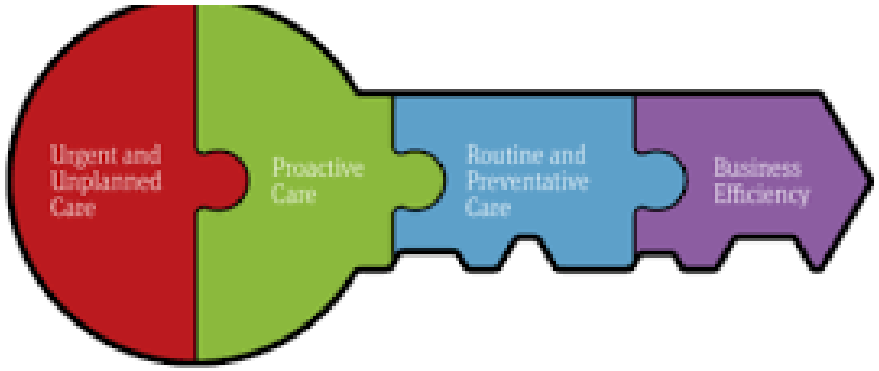
(iv) providing services that are tailored to a person's mental and physical needs and their circumstances and preferences; and

(v) providing services that reflect mātauranga Māori:

- Active Protection and Equity
- Partnership
- Tino Rangatiratanga
- Options

We aligned the Health Care Home Model of care with Pae Ora

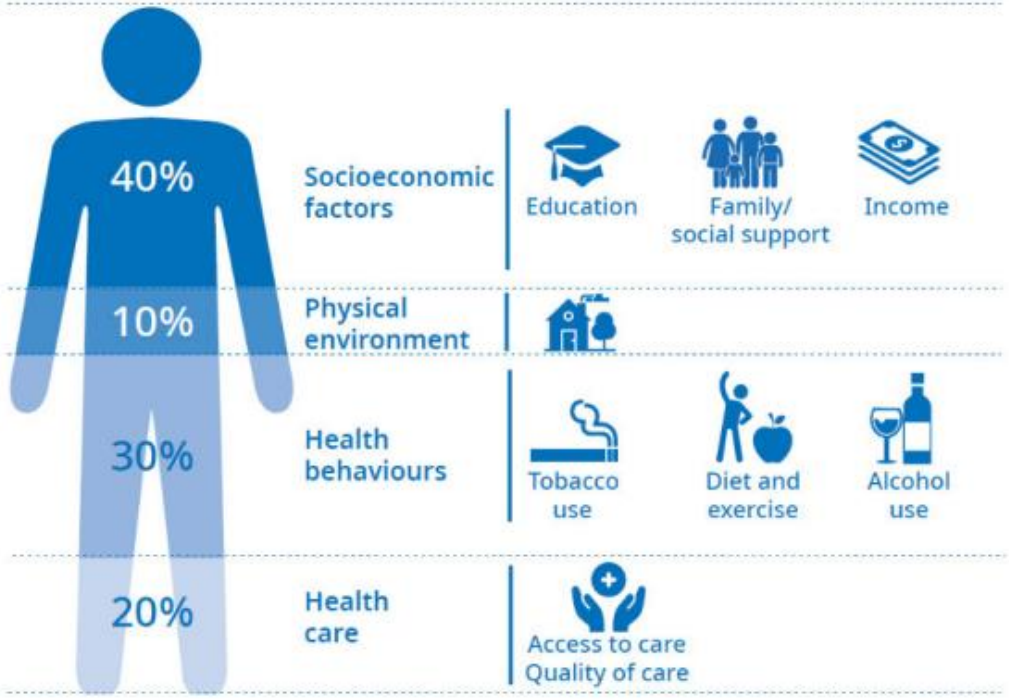
2011



2020

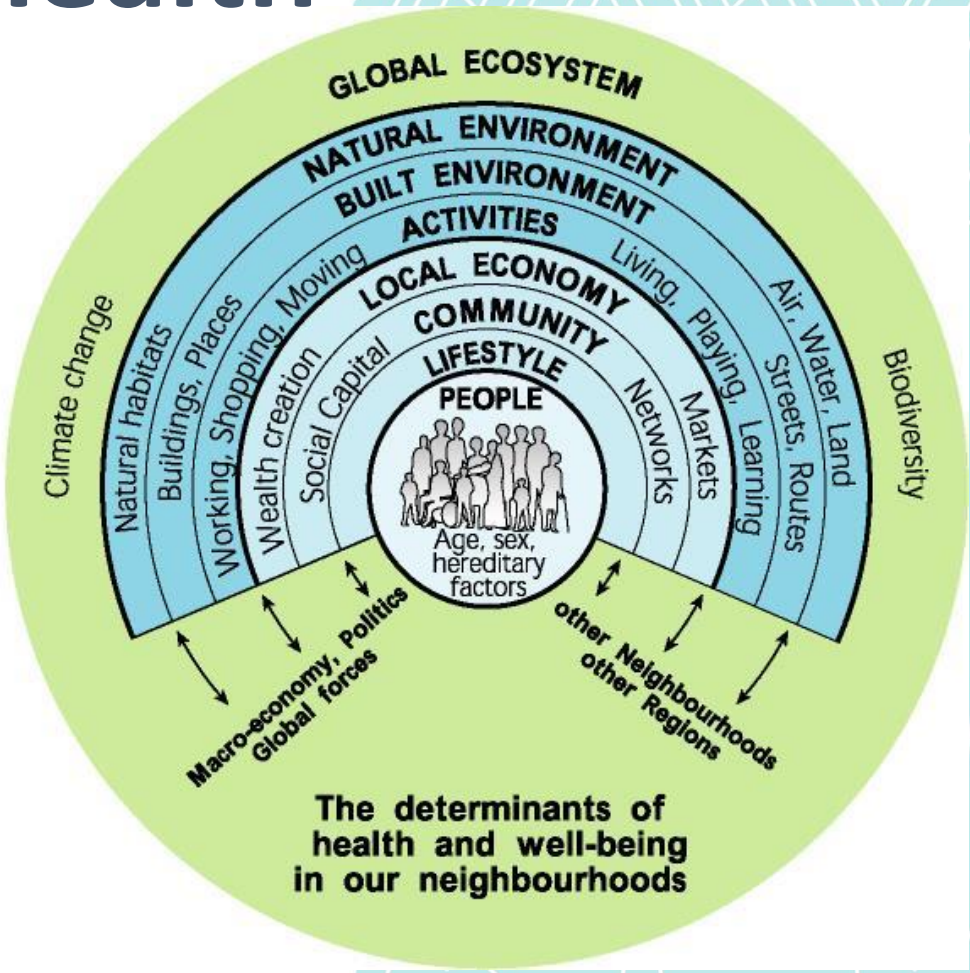
To bring Pae Ora to life we need more than health care

Figure 3: The determinants of health and their relative contribution to our health outcomes



Source: Adapted from the Institute for Clinical Systems Improvement (2014)

We must acknowledge and address the determinants of health- including racism



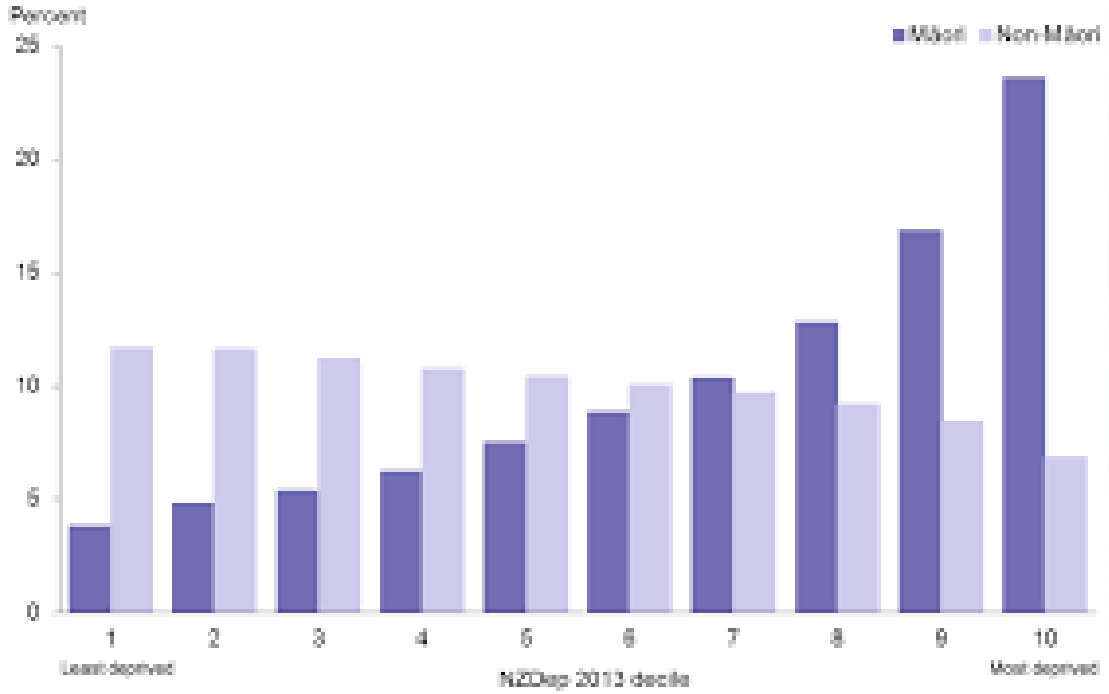
A Health Map for the Local Human Habitat, Barton and Grant (2006) based on a public health concept by Dahlgren and Whitehead (1991).

We need to give Climate change and biodiversity restoration significant attention

OraTaiao

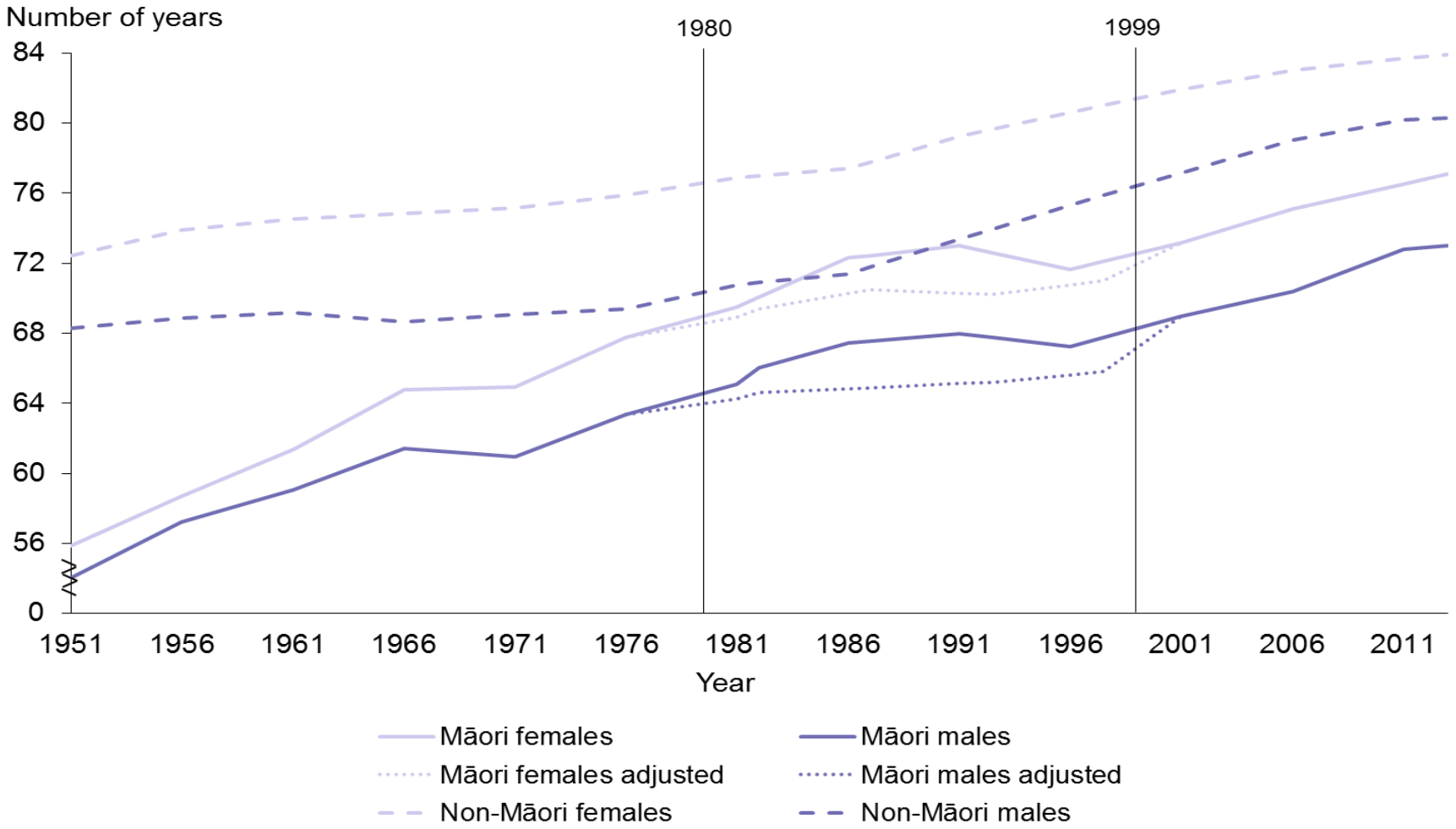
NZ Climate & Health Council

We know that a higher proportion of Māori have poorer access to the social and economic determinants of health, compared to non-Māori



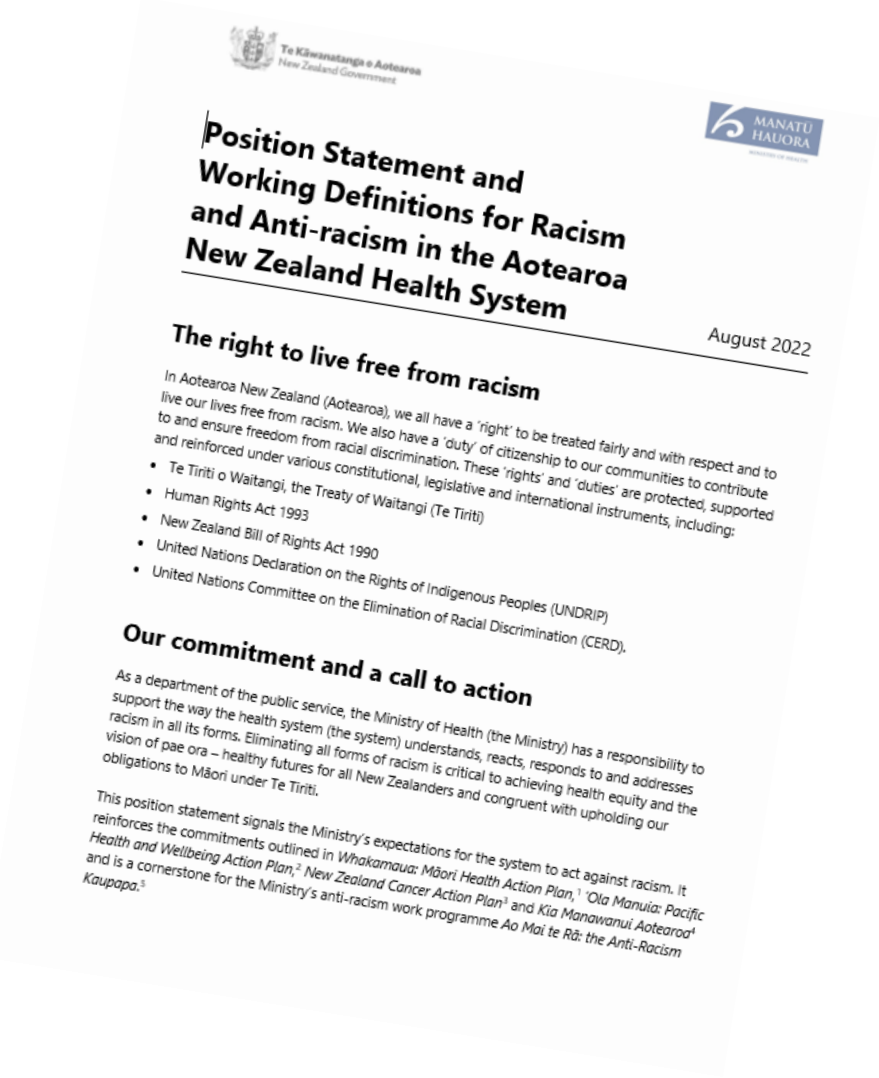
https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-awe-o-te-hauora-socioeconomic-determinants-health/neighbourhood-deprivation

Which leads to inequities in life expectancy…



We know a major contributor of these socio-economic and health inequities are colonisation and racism

- ***Racism*** *comprises racial prejudice and societal power and manifests in different ways. It results in the unequal distribution of power, privilege, resources and opportunity to produce outcomes that chronically favour, privilege and benefit one group over another. All forms of racism are harmful, and its effects are distinct and not felt equally.*



Te Kāwanatanga o Aotearoa
New Zealand Government

MANATŪ HAUORA

Position Statement and Working Definitions for Racism and Anti-racism in the Aotearoa New Zealand Health System

August 2022

The right to live free from racism

In Aotearoa New Zealand (Aotearoa), we all have a 'right' to be treated fairly and with respect and to live our lives free from racism. We also have a 'duty' of citizenship to our communities to contribute to and ensure freedom from racial discrimination. These 'rights' and 'duties' are protected, supported and reinforced under various constitutional, legislative and international instruments, including:

- Te Tiriti o Waitangi, the Treaty of Waitangi (Te Tiriti)
- Human Rights Act 1993
- New Zealand Bill of Rights Act 1990
- United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)
- United Nations Committee on the Elimination of Racial Discrimination (CERD).

Our commitment and a call to action

As a department of the public service, the Ministry of Health (the Ministry) has a responsibility to support the way the health system (the system) understands, reacts, responds to and addresses racism in all its forms. Eliminating all forms of racism is critical to achieving health equity and the vision of pae ora – healthy futures for all New Zealanders and congruent with upholding our obligations to Māori under Te Tiriti.

This position statement signals the Ministry's expectations for the system to act against racism. It reinforces the commitments outlined in *Whakamaua: Māori Health Action Plan*,[1] *'Ola Manuia: Pacific Health and Wellbeing Action Plan*,[2] *New Zealand Cancer Action Plan*[3] and *Kia Manawanui Aotearoa*[4] and is a cornerstone for the Ministry's anti-racism work programme *Ao Mai te Rā: the Anti-Racism Kaupapa*.[5]

We must re-distribute resources for a just society, and to bring Pae Ora to life

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Pae Ora (Healthy Futures) Bill supports our duty to act, including address the determinants of health

(e) the health sector should protect and promote people's health and wellbeing, including by—

(i) adopting population health approaches that prevent, reduce, or delay the onset of health needs; and

(ii) undertaking promotional and preventative measures to protect and improve Māori health and wellbeing; and

(iii) working to improve mental and physical health and diagnose and treat mental and physical health problems equitably; and

(iv) collaborating with agencies and organisations to address the wider determinants of health; and

(v) undertaking promotional and preventative measures to address the wider determinants of health, including climate change, that adversely affect people's health.

(2) When performing a function or exercising a power or duty under this Act, the Minister, the Ministry, and each health entity must be guided by the health sector principles—

(a) as far as reasonably practicable, having regard to all the circumstances, including any resource constraints; and

(b) to the extent applicable to them.

Nō reira, to bring Pae Ora to life we must:

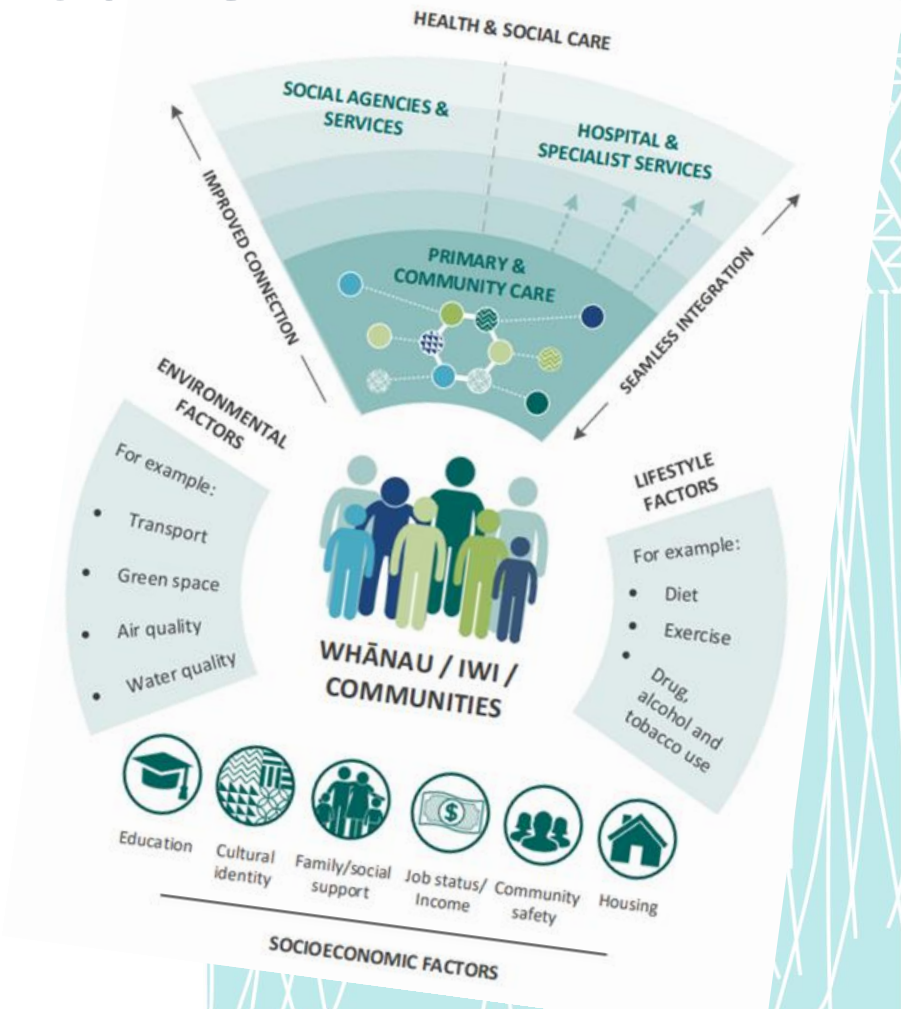
- Address the determinants of health at all levels
- Acknowledge racism as a key determinant of health
- Work collectively to improve the determinants of health aligning with the Principles of Te Tiriti o Waitangi

Primary and community care

- Person and whānau centred
- Affordable care
- Continuous Care
- Comprehensive care
- Coordinated care

- Note Vote Health Budget

Declaration of Astana – Global Conference on Primary Health Care (2018[7]), https://www.who.int/docs/default-source/primaryhealth/declaration/gcphc-declaration.pdf

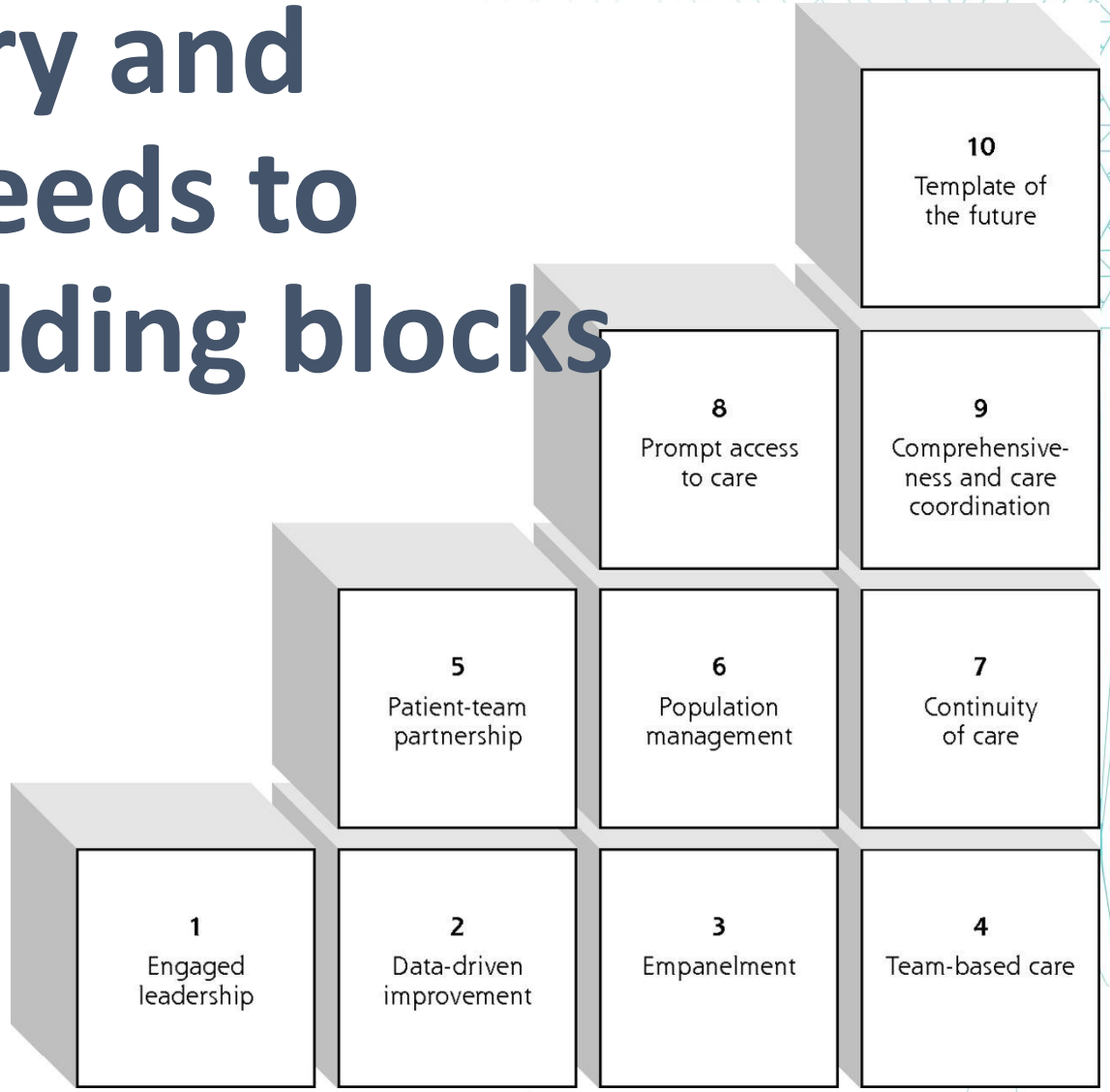


https://dpmc.govt.nz/sites/default/files/2021-04/htu-factsheet-primary-and-community-care-en-apr21.pdf

Done well, primary and community care leads to improved population health and reduced inequities

OECD (2020), *Realising the Potential of Primary Health Care*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/a92adee4-en.

To run well, primary and community care needs to consider these building blocks

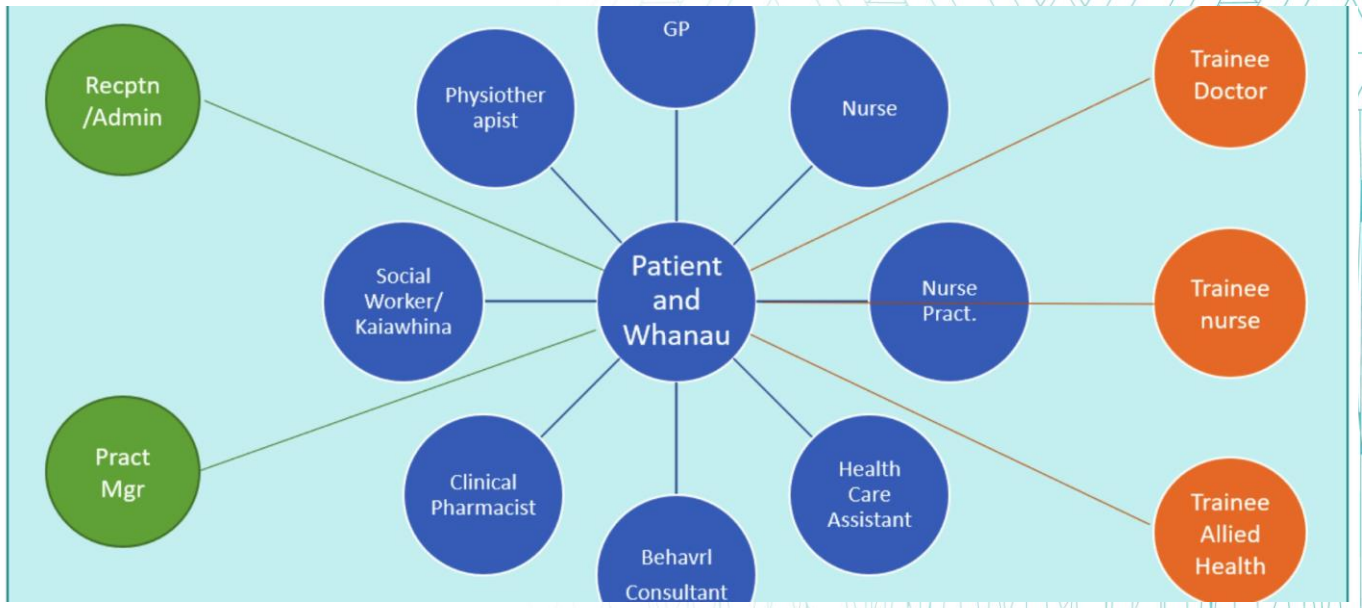


The 10 Building Blocks of High-Performing Primary Care
Thomas Bodenheimer, Amireh Ghorob, Rachel Willard-Grace and Kevin Grumbach
The Annals of Family Medicine March 2014, 12 (2) 166-171; DOI: https://doi.org/10.1370/afm.1616

The highly skilled workforce wrap mana-enhancing services around the patient and whānau

Refer to:

- Nuka Model
- Hutt Union Model
- Ora Toa Model
- Takiri Mai te Ata
- Mauri Ora Model
- Turuki Model



For high needs practices, the staff and processes are trauma-informed and culturally competent

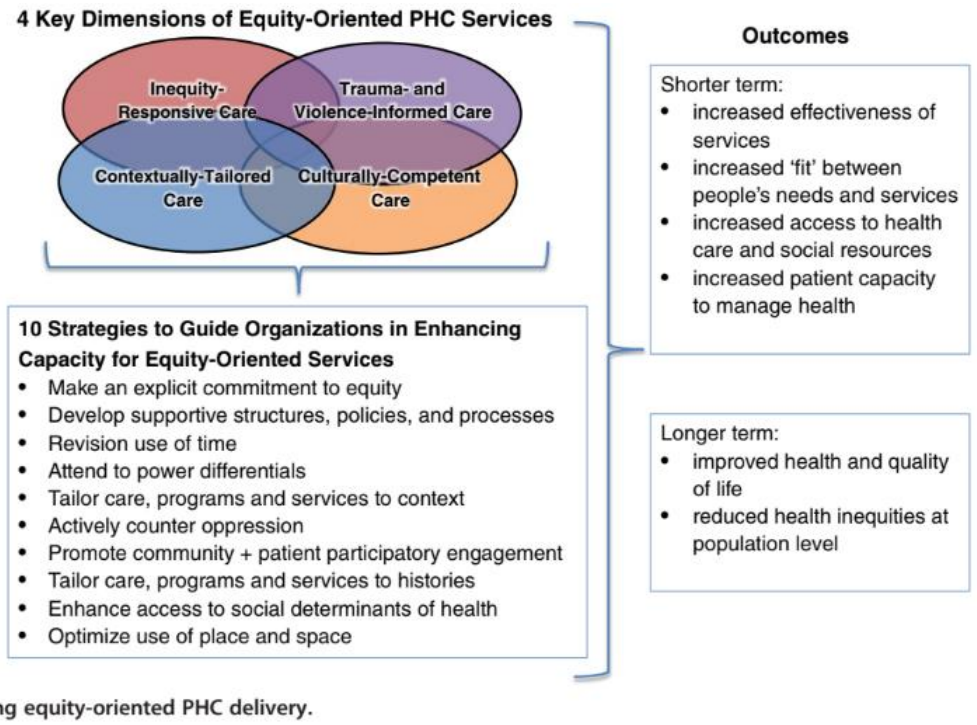


Figure 1 Enhancing equity-oriented PHC delivery.

Browne et al. Closing the health equity gap: evidence-based strategies for primary health care organizations International Journal for Equity in Health 2012, 11:59
http://www.equityhealthj.com/content/11/1/59

Figure 4. Receptionists looking like Mum (by Moana).

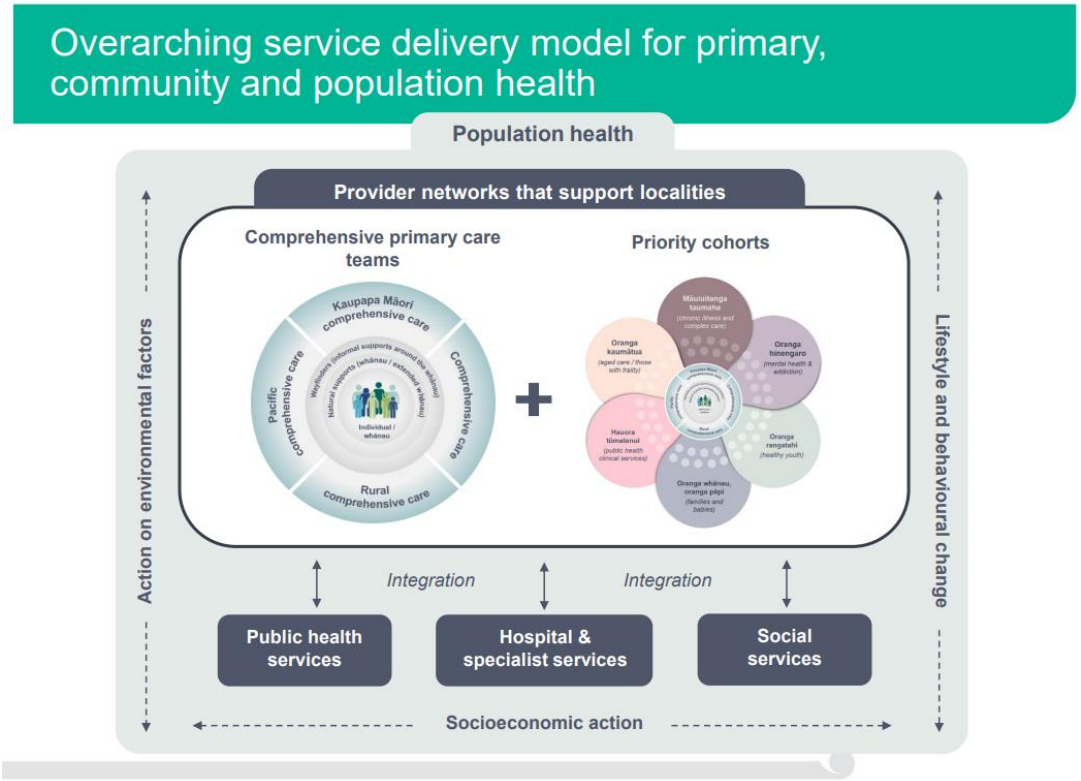
Kyle Eggleton, Robin Kearns & Pat Neuwelt (2017) Being patient, being vulnerable: exploring experiences of general practice waiting rooms through elicited drawings, Social & Cultural Geography, 18:7, 971-993, DOI: 10.1080/14649365.2016.1228114

There are many enablers of whānau centred primary health care and support services

Figure 1: Various layers affecting whānau-centred primary health care

https://www.tpk.govt.nz/en/o-matou-mohiotanga/health/te-piringa-whanaucentred-primary-health-care

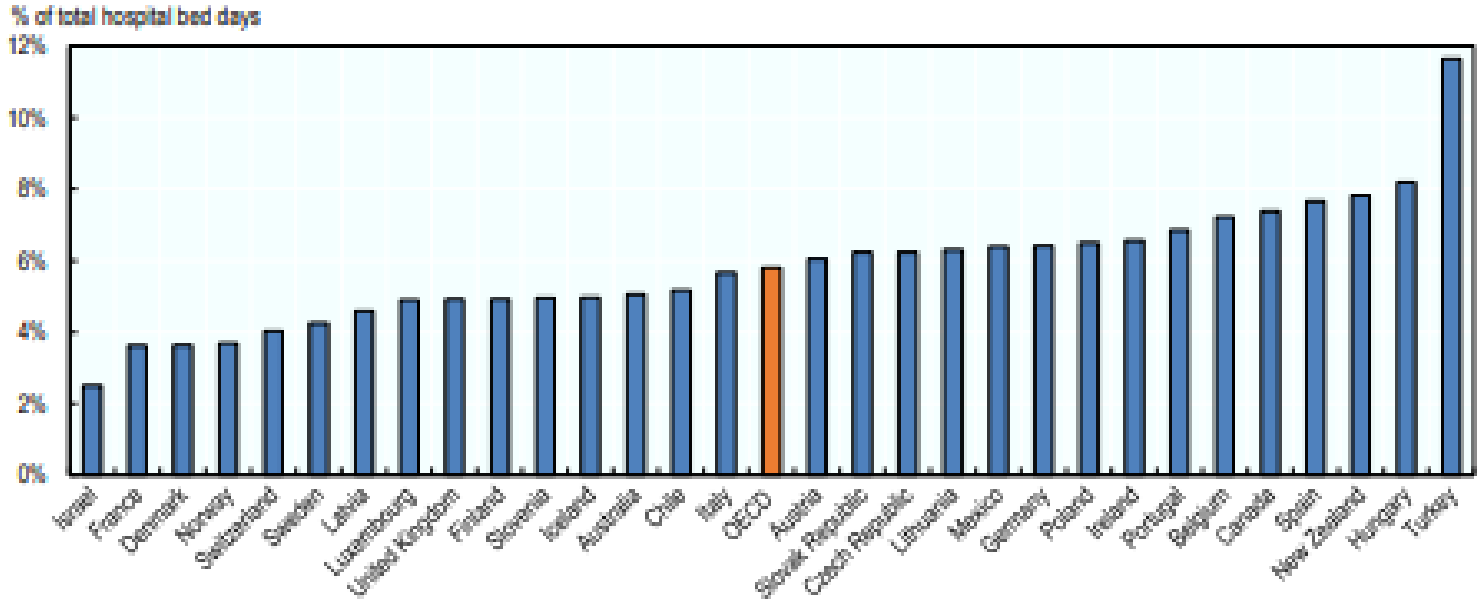
So far the locality service delivery models, on paper, aligns with the evidence and our duty



Interim Health NZ and Māori Health Authority Health System Reforms – Localities Local Government – Mayors, Chairs & Chief Executives May 2022

When we look at our data, our Ambulatory Sensitive Hospitalisations rates are high, relative to OECD countries

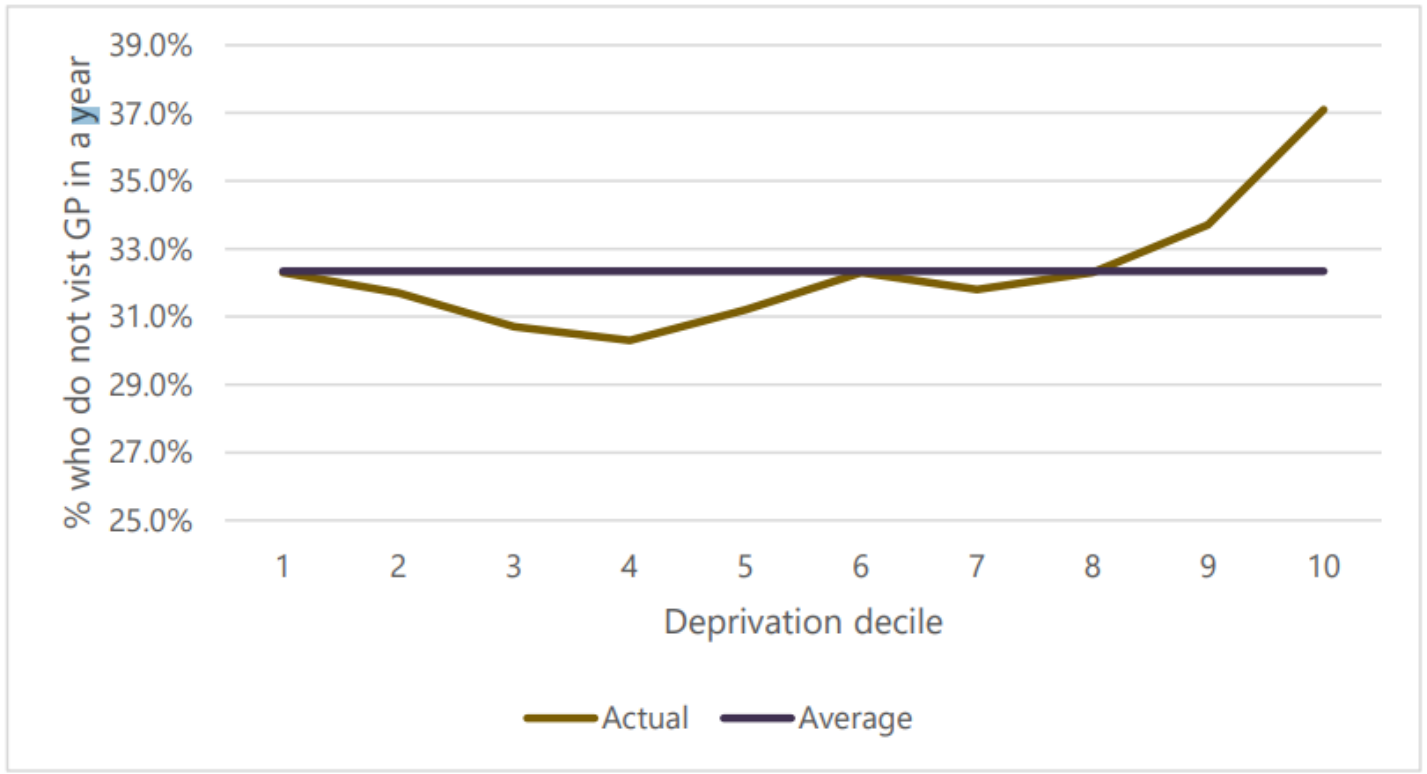
Figure 1.2. Share of potentially avoidable hospital admissions due to five chronic conditions as a percentage of total hospital bed days, 2016



OECD (2020), *Realising the Potential of Primary Health Care*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/a92adee4-en.

Our highest need communities struggle to access primary health care

Figure 6: Percentage of population that does not visit a GP in a year versus socioeconomic deprivation decile



https://srgexpert.com/wp-content/uploads/2021/08/Methodology-for-Estimating-the-Underfunding-of-Maori-Primary-Health-Care.pdf

Many primary and community services have lost the comprehensive services they once had

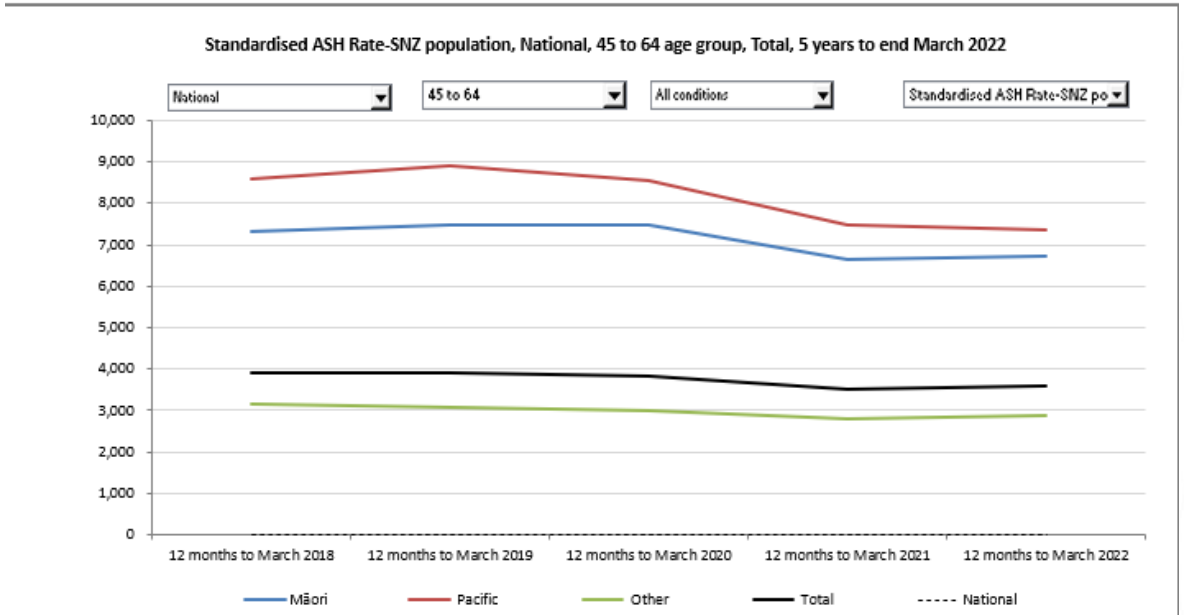
For example:

- Maternity services at Hutt Union and Porirua Union are no longer

- Ora Toa is struggling to maintain it’s dental services

Ambulatory Sensitive Hospitalisations remain approx. 2x for Māori

SI 1: Ambulatory Sensitive Hospitalisations (ASH)



DHB	Ethnic Group	12 months to March 2018	12 months to March 2019	12 months to March 2020	12 months to March 2021	12 months to March 2022
National	Māori	7,339	7,469	7,463	6,642	6,739
National	Pacific	8,586	8,911	8,544	7,470	7,370
National	Other	3,172	3,084	3,001	2,793	2,869
National	Total	3,910	3,895	3,818	3,502	3,590
-	-	-	-	-	-	-

And while we are on inequities, at the Census Area Unit, (mean pop. 2100), the difference between the shortest and longest lived populations in Aotearoa is:

- A: 7 years
- B: 10 years
- C: 14 years
- D: 22 years
- E: 29 years

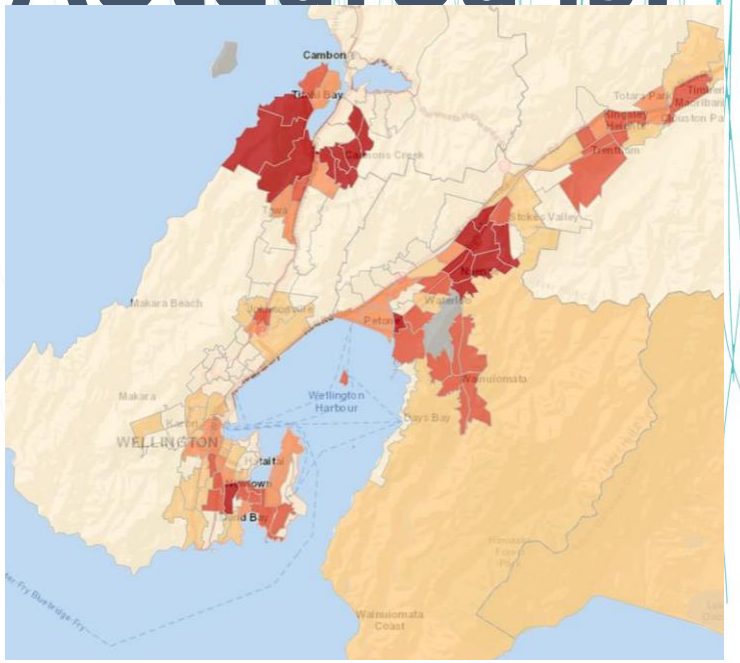
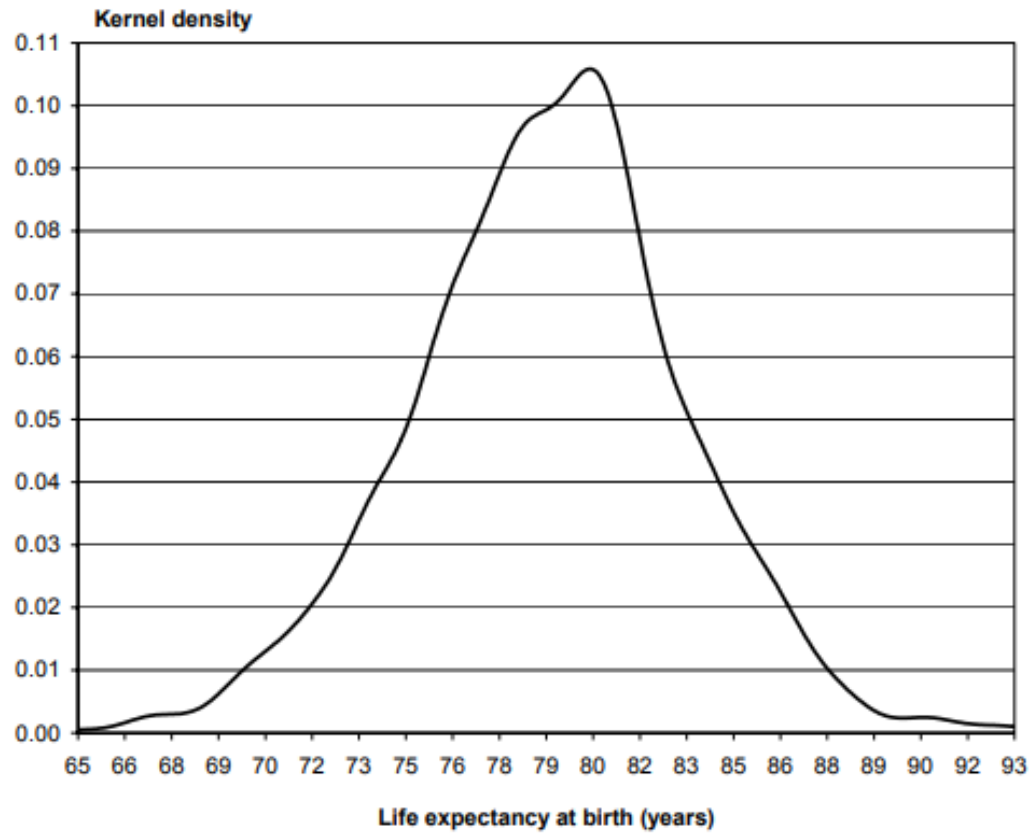
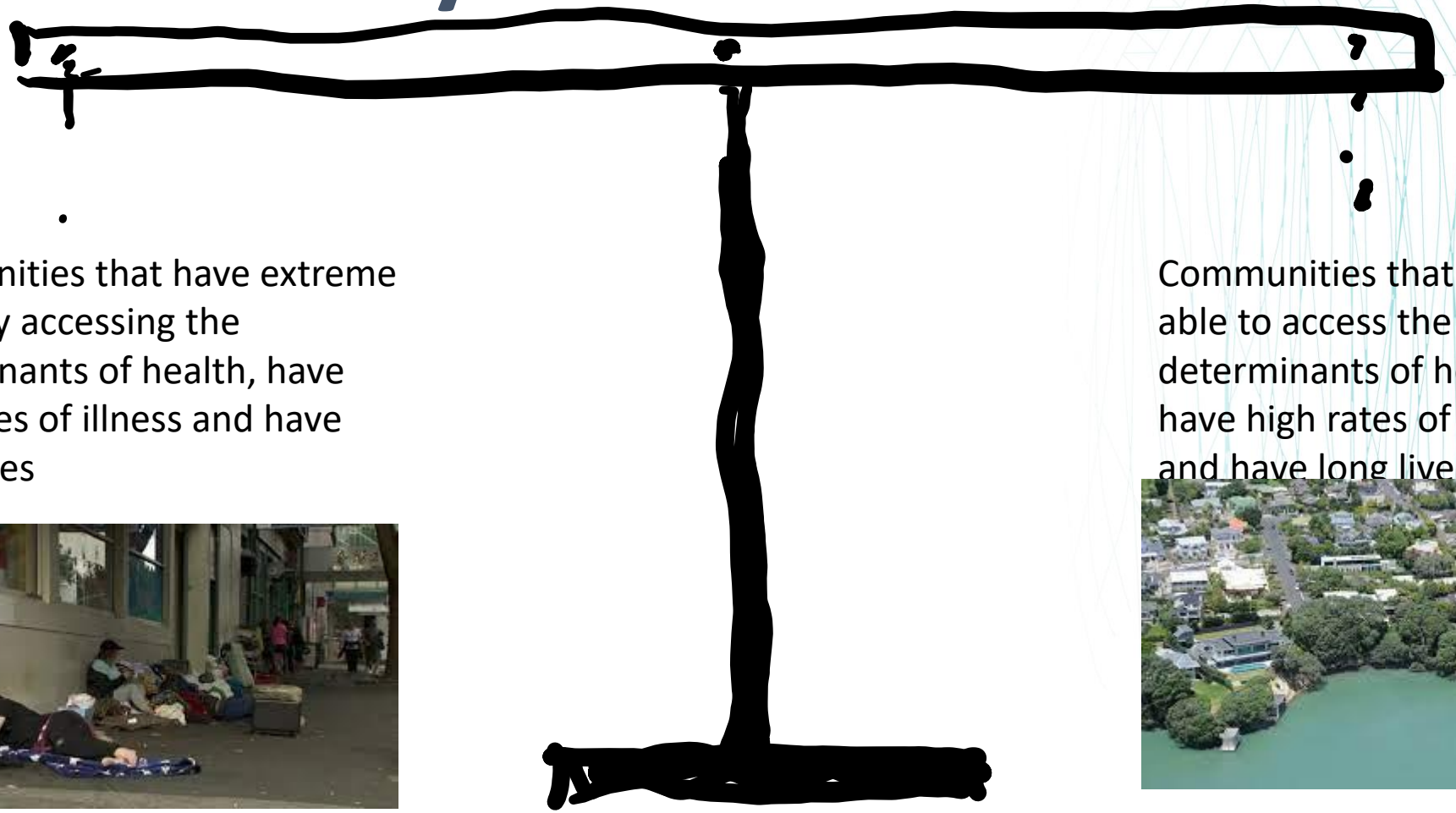


Figure 2: Distribution of neighbourhood life expectancies, New Zealand, 1999–2003 (kernel density smoothed)



Ministry of Health. 2005. Monitoring Health Inequality Through Neighbourhood Life Expectancy: Public Health Intelligence occasional bulletin no. 28. Wellington: Ministry of Health.

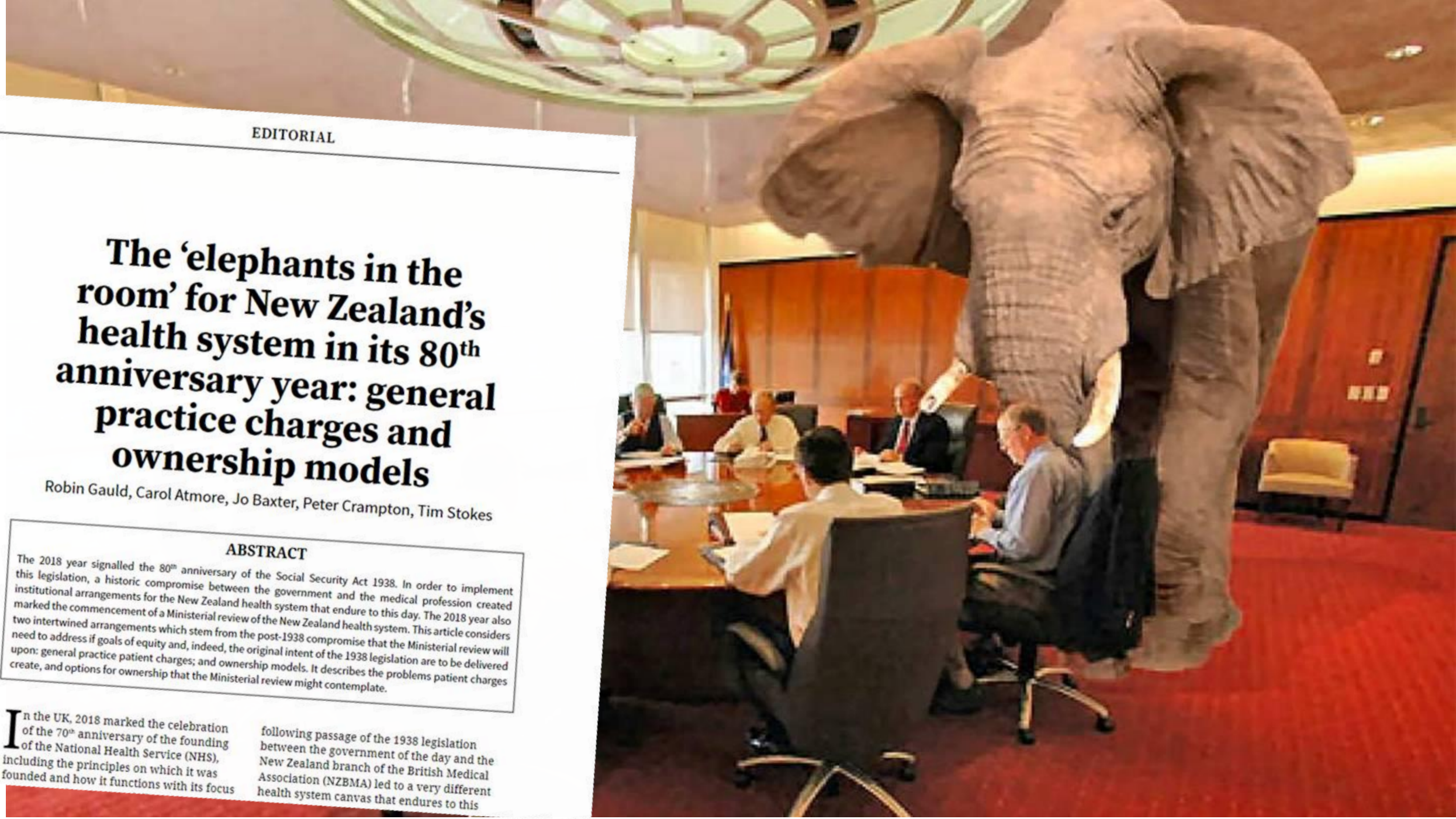
In Aotearoa, we have populations that are vastly different.



Communities that have extreme difficulty accessing the determinants of health, have high rates of illness and have short lives

Communities that are able to access the determinants of health, have high rates of illness and have long lives

Yet the difference in the primary and community care policy settings for these two extremes is minimal



The 'elephants in the room' for New Zealand's health system in its 80th anniversary year: general practice charges and ownership models

Robin Gauld, Carol Atmore, Jo Baxter, Peter Crampton, Tim Stokes

ABSTRACT

The 2018 year signalled the 80th anniversary of the Social Security Act 1938. In order to implement this legislation, a historic compromise between the government and the medical profession created institutional arrangements for the New Zealand health system that endure to this day. The 2018 year also marked the commencement of a Ministerial review of the New Zealand health system. This article considers two intertwined arrangements which stem from the post-1938 compromise that the Ministerial review will need to address if goals of equity and, indeed, the original intent of the 1938 legislation are to be delivered upon: general practice patient charges; and ownership models. It describes the problems patient charges create, and options for ownership that the Ministerial review might contemplate.

In the UK, 2018 marked the celebration of the 70th anniversary of the founding of the National Health Service (NHS), including the principles on which it was founded and how it functions with its focus following passage of the 1938 legislation between the government of the day and the New Zealand branch of the British Medical Association (NZBMA) led to a very different health system canvas that endures to this

Waitangi Tribunal recommendations in the Wai2575 report in 2019

On the broader question of funding generally for the primary health care system, we recommend that the Crown conduct an urgent and thorough review of funding for primary health care, to better align it with the aim of achieving equitable health outcomes for Māori.

In relation to funding, we have made an interim recommendation that the Crown and stage one claimants agree upon a methodology for the assessment of underfunding of Māori primary health organisations and health providers. The methodology should include an assessment of establishment and ongoing underfunding since the commencement of the Act. We have directed the parties to report back to us by 20 January 2020 on progress.

In relation to accountability arrangements, we recommend that the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health care sector which impact upon Māori.

The Waitangi Tribunal commissioned Sapere to estimate the underfunding of Māori Primary Health.

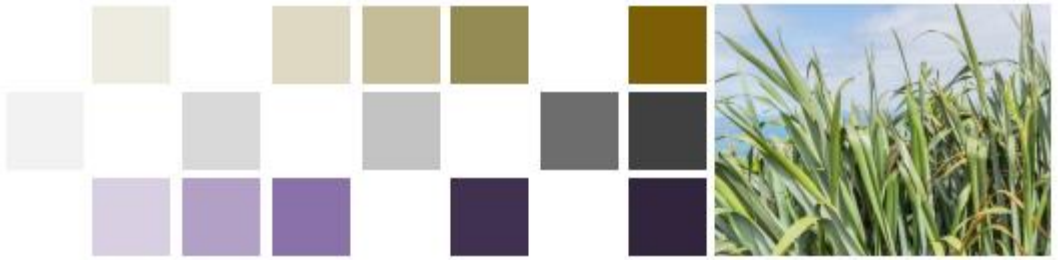
-

Methodology for Estimating the Underfunding of Māori Primary Health Care

Methodology and proof of concept with key results

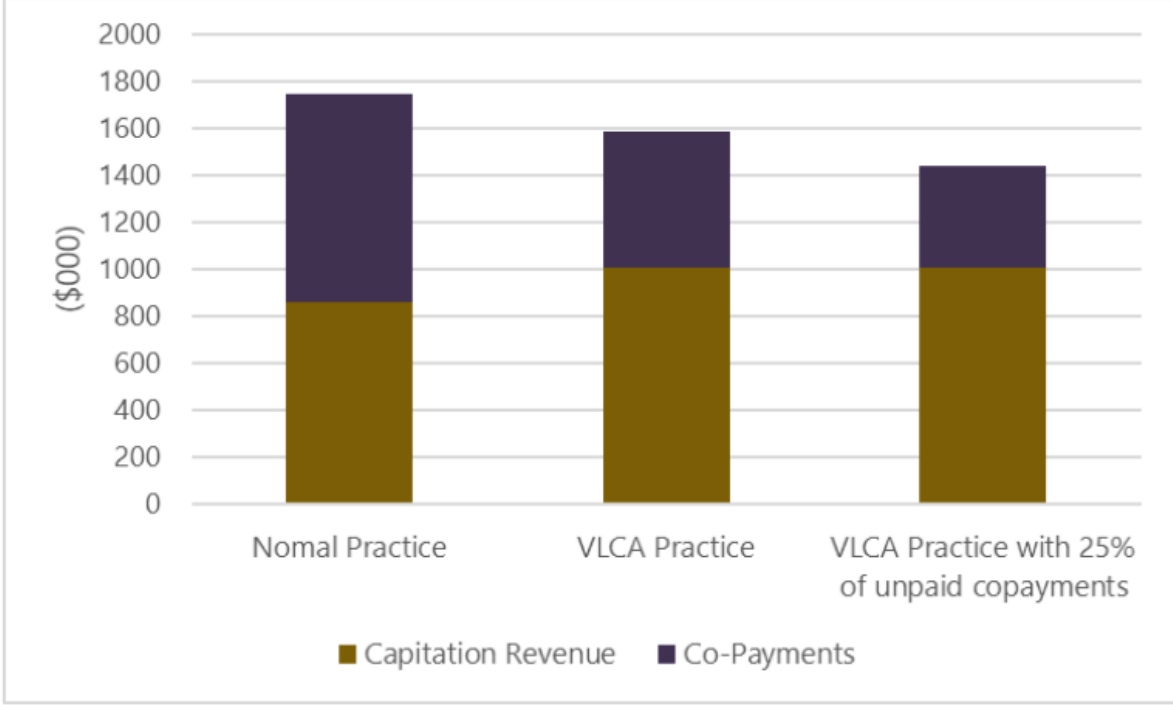
Dr Tom Love, David Moore, Ashley Milkop, Lockie Woon, Michael Young, Corina Comendant

27 July 2021



Funding does not increase for primary care practices serving high needs populations

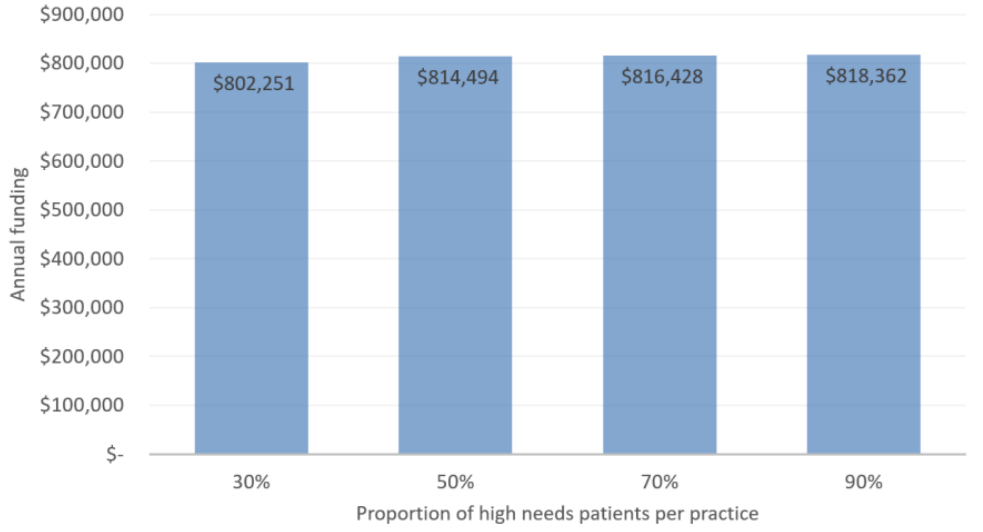
Funding for a non-VLCA practice relative to a VLCA practice with 5,000 patients



https://srgexpert.com/wp-content/uploads/2021/08/Methodology-for-Estimating-the-Underfunding-of-Maori-Primary-Health-Care.pdf

Primary care funding does not account for the concentrations of complexity that we see in these areas

Figure 2: Capitation funding totals for each hypothetical practice



Dr Mona Jeffreys 2021,Do general practice capitation fees account for concentrations of complexity? Te Hikuwai Rangahau Hauora | Health Services Research Centre Te Herenga Waka Victoria University of Wellington
https://insightsaotearoa.ac.nz/wp-content/uploads/2022/01/Do-GP-capitation-fees-account-for-concentrations-of-complexity.pdf

And in addition to funding shortfalls, it is well documented Māori providers are over-audited and their contracts are shorter (than mainstream providers

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand

H. Came [a, *], C. Doole [a], B. McKenna [a], T. McCreanor [b]

[a] Faculty of Health and Environment Sciences, Auckland University of Technology, Private Bag 92006, Auckland, New Zealand
[b] Te Rōpū Whāriki, Massey University, PO Box 6137, Wellesley Street, Auckland 1141, New Zealand

These funding inequities, for starters, are very expensive. We recognise the enablers like data, quality improvement tools such as we see in Health Care Home. But if we do not address the issue of funding, and accountability it may be very difficult to bring Pae Ora to life

"The cost of underfunding and under-provision of primary health care for Māori is borne by Māori. For the 2018 Māori population aged under five, and between 45 to 64 ….. we estimate that the annual health loss in 2018 due to inadequate primary care is valued at $5 billion".

https://srgexpert.com/wp-content/uploads/2021/08/Methodology-for-Estimating-the-Underfunding-of-Maori-Primary-Health-Care.pdf

We need equitable funding that considers the characteristics of the populations we serve. Sapere and GPNZ have started to outline a process

Table 4: Comprehensive primary care PHO

Profession	FTEs (5,000 population)	Cost 5,000 population ($000)
Admin – Business managers	2.0	$240
Admin – Reception staff	6.0	$312
Admin – Office managers	2.0	$160
ARC Activities coordinators	0.8	$39
ARC Caregivers	7.4	$330
ARC Enrolled nurses	0.8	$45
ARC Registered nurses	1.4	$92
Behaviourist	0.5	$40
Dental hygienists	3.0	$219
Dental technicians	0.3	$20
Dentists and dental specialists	2.1	$375
General practitioners	4.0	$711
Nurse practitioners	2.5	$251
Healthcare assistant	2.0	$90
Kaumātua/Kuia	2.0	$161
Kaiāwhina	6.0	$351
Midwives	2.1	$157
Nurses	4.2	$338
Psychologists/counsellors	2.0	$214
Pharmacist	1.3	$98
Pharmacy interns	0.3	$15
Physiotherapists	0.3	$20
Podiatrists	1.5	$122
Rongoā practitioners	2.6	$213

	High need		Non-High Need	
Cost Centre	**FTE/10,000**	**Cost**	**FTE/10,000**	**Cost**
GP	7.9	$2,212,000	5.5	$1,540,000
Nurse practitioner	5.0	$550,730	2.0	$220,292
Nurse	8.4	$650,521	7.3	$565,334
Reception/admin	6.7	$333,333	5.0	$250,000
Behaviourist/counsellor	1.0	$90,862	0.5	$45,431
CHW/SW/cultural	2.5	$181,930	1.0	$72,772
HCA	4.0	$194,792	3.0	$146,094
Clinical pharmacist	0.5	$45,431	0.5	$45,431
Physiotherapist	0.5	$45,431	0.5	$45,431
Manager	1.0		1.0	
Trainee doctor	1.0		1.0	
Trainee nurse	1.0		1.0	
Trainee allied health	1.0		1.0	
Students	2.0	$120,000	2.0	$120,000
IT/communications		$30,000		$25,000
Rental/capital		$269,578		$223,168
Consumables		$177,001		$122,031
Cover for leave		$442,503		$305,078
ACC/kiwisaver etc.		$199,126.37		$137,285.32
Total		**$5,543,239**		**$3,863,348**

Figure 5 Estimated total service cost for 10,000 enrolled population

https://srgexpert.com/wp-content/uploads/2021/08/Methodology-for-Estimating-the-Underfunding-of-Maori-Primary-Health-Care.pdf

https://gpnz.org.nz/wp-content/uploads/Workforce-Resources-FINAL-DISCUSSION-DOC.pdf

To bring Pae Ora to life we must:

- Refocus more attention and resources towards primary and community care
- Enable skilled staff to run primary and community care that aligns with the aspirations of their communities

- Equitably fund primary and community care provider that serve the communities of highest need

Figure 4. Receptionists looking like Mum (by Moana).

Nāu te rourou, nāku te rourou, ka ora ai te iwi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